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EDITORIAL

International Journal of Risk and Recovery, beginning of an exciting journey

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Sébastien Prat is an Assistant Professor at McMaster University and a Staff Psychiatrist at St. Joseph's Healthcare Hamilton. His medical training and residency in Psychiatry took place at the University François Rabelais of Tours in France. He underwent a subspecialty training in Forensic Psychiatry at McMaster University. He is the Executive Editor of the International Journal of Risk and Recovery.

A few years ago, members of the forensic psychiatry research team at St. Joseph's Healthcare Hamilton started an exciting journey with the decision to create a new forensic mental health journal.

The project arose from the success of an annual conference, the Risk and Recovery Forensic Conference, that brings professionals from the criminal justice and mental health systems together in sharing expertise and experiences when working with offenders and victims. The conference has been an avenue to share practice experiences, to learn from others on a national and international platform, and to bring hope and support to individuals with mental illness who are in the recovery process following contact with the criminal justice system.

The International Journal of Risk and Recovery found its name echoing the conference and the purpose of this new journal also parallels the stimulating framework of the conference. It aims in providing topical scholarly and scientific publications and in offering practical knowledge that professionals, academics, and frontline staff can become inspired to implement.

Creating a journal is an exciting process when you're working with highly motivated contributors. We have been fortunate to be collaborating with McMaster University Library Press who have provided access to the Open Journal Access System software. This system enables us to develop free content for both authors and our readers. The ease of accessibility aligns with our goal to not only publish academic papers but also to include relevant topics and practical knowledge that resonate with professionals' daily practices.

Developing a scientific journal also has inherit challenges and as the International Journal of Risk and Recovery seeks to attract authors' submission for high-quality publications, we also recognize that the journal has yet to gain a strong impact factor and currently has a limited number of database references. Like all early projects, indexing a journal in databases requires time and it is our mission to obtain an impact factor through the promotion of papers to databases according to their criteria.

As with any journal, obtaining reviewers that can dedicate their time and contribute their expertise in the selection of articles is an ongoing task. With time we expect to increase the number of our collaborators and improve the timeline process for reviewing of submissions. We are thankful for those who have dedicated their time already and have been helping in the peer review analysis of manuscripts.

Accessibility and availability of information is our primary goal for publishing a free of

charge journal, but it also requires motivated volunteers to hold some of the publishing positions, such as copyediting, layout editing, and proofreading. We have been fortunate to find individuals, volunteers and staff at St Joseph's Healthcare Hamilton and McMaster University to participate in the publication process and their contribution is gratefully acknowledged. We also welcome those interested in having an editorial experience to become part of our team.

The editorial and management team of the International Journal of Risk and Recovery will continue to work hard to offer high-quality scholarly content. We are thankful to our authors and readers in being part of our journey and we're excited to continue expanding our scholarly impact with interested colleagues.

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ORIGINAL ARTICLE

Is the anticipated consent to treatment in advance directives a solution to compulsory treatment in forensic psychiatry?

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As a result of a German Federal Constitutional Court decision on compulsory treatment, in its state Law the federal state of Hesse has newly regulated the possibility of compulsory treatment (Section 7 Paragraph 2 of the Hesse Law on the Enforcement of Court-ordered Hospital Treatment) and expressly incorporated the observance of a patient's advance directive as defined by Sections 1901a and 1901b of the German Civil Code (Bürgerliches Gesetzbuch [BGB]). Having been sentenced to a hospital treatment order under section 63 of the German Criminal Code (Strafgesetzbuch [StGB]) in the Vitos Haina Forensic Psychiatric Hospital, thirteen patients with schizophrenia stated in a patient's advance directive that they wished to be treated with certain antipsychotic medication in case of a recurring psychotic episode. In particular, the patient's advance directive stated that this treatment should be compulsory if necessary. Based on a case vignette this article delineates both the motivation of the patients for such a patient's advance directive, as well as the legal limitations and the enforceability of such a patient's advance directive. There is no prevailing view in the jurisdiction or literature on the utilization of a patient's advance directive to guarantee an explicitly desired treatment in case of incapacity for consent. This article wishes to highlight the perspectives of those directly affected and to encourage discussion. While of special interest for forensic psychiatry, these considerations may also be of importance for treatment considerations in general psychiatry.

Key words

Patient's advance directive, Anti-psychotic medication, Coercive treatment, Forensic psychiatry, General psychiatry

Introduction

In Germany, the discussion about the use of compulsory treatment has been rekindled by changes in the legal system.

Questioning, debating, and defining the legal possibility of compulsory treatment is essential in contemporary psychiatry since compulsory treatment is a significant burden on patient autonomy.

Yet, the patient, who is assigned against their will and for reasons of protection (general psychiatry), or was declared not to be criminally responsible for the crime committed (forensic psychiatry), is often not motivated for treatment but poses a risk for fellow patients or fellow inmates, staff and him/herself.

The following article introduces the possibility of an anticipated consent to treatment in advance directives (Ulysses clause) as one means to solve this problem.

Legal aspects of compulsory treatment in the forensic context

The German Criminal Code (Strafgesetzbuch [StGB]) Section 63 sets out the legal grounds for involuntary placement in a forensic psychiatric hospital for persons who are declared not criminally responsible or who have diminished responsibility for a criminal offense. Placements under Section 63 may be indefinite.

Whether the compulsory treatment of a person detained under section 63 of the German Criminal Code (Strafgesetzbuch [StGB]) is permissible depends on the regulations governing such detention in the respective state of Germany. In the state of Hesse this matter is governed by

section 7a of the Law on the Enforcement of Court-ordered Hospital Treatment in a Psychiatric Hospital, and in a Drug Rehabilitation Facility of the State of Hesse (Hessisches Maßregelvollzugsgesetz [hereinafter HMRVG]). It is specified that:

(1) Medical examinations and treatments, as well as nutrition, are permissible against the natural will of a detained person who is incapable of giving consent if:

1. *significant danger for the life of the detainee or a serious impairment to their health exists,*
2. *this is necessary to restore the detainee's ability to take decisions and action, and if there are grounds to assume that without the implementation of the measure in question, the detainee's discharge will not be possible.*

(2) Medical examinations and treatments, as well as nutrition, are permissible against the natural will of a detained person if significant danger to the life, or a serious impairment of the health, of the persons exists.

(3) Compulsory measures as defined in subsections 1 and 2 may be ordered only if:

1. *attempts to produce the consent of the detainee to the examination, treatment, or nutrition that is based on trust, have not been successful,*
2. *the detainee has been informed of the order, and a physician has explained the nature, scope, and duration of the therapeutic measure,*
3. *the measure required to avert danger to life, limb, or health, or to restore freedom, does not entail unreasonable stress or consequences for the detainee and more gentle measures do not promise any success, and*
4. *the anticipated benefit of the measure clearly outweighs any possible harm from the failure to provide treatment.*

In the event of imminent danger, the requirements defined in numbers 1 and 2 can be disregarded.

(4) Compulsory measures pursuant to subsections 1 and 2 shall be initiated and monitored by a physician in accordance with section 2, sentence 6. The reasons for a hospital treatment order as defined in subsections 1 and 2, the conditions defined in subsection 3, and the measures taken (e.g. their compulsory character, the manner of implementation , the monitoring of effects, and the sequence of examinations and course of treatment) are to be documented.

(5) Treatment based on an order as defined in subsection 3 shall be subject to the prior approval of the supervisory authority. Such approval shall not be required if danger is imminent and the approval is procured immediately after initiating the measure. Application for a decision of the court against the order may be filed in accordance with section 109 of the German Prison Act (Strafvollzugsgesetz [StVollzF]).

(6) To ensure the protection of health and hygiene of the detained person, compulsory physical examination is permitted if it is not combined with an invasive physical intervention.

The question of compulsory treatment arises only when a patient refuses to consent to drug therapy despite the therapy regime having been explained on several occasions, and attempts having been made to reach agreement with the patient. The German Federal Constitutional Court (Bundesverfassungsgericht [BVerfG]) once again clarified, in its decisions from the years 2011 and 2013, that compulsory treatment is fundamentally possible [1]), although it imposed far-reaching specifications for an adequate legal framework [1-3].

According to these specifications, compulsory medical treatment represents a serious intervention in the basic rights of a patient, as derived from article 2, subsection 2, sentence 1 of the Basic Law for the Federal Republic of Germany (Grundgesetz [GG]). In individual cases, such intervention can be justified to achieve the goals of the forensic commitment. Yet, there are strict requirements for the permissibility of such intervention in terms of proportionality [1]. These apply to both the material requirements for such an intervention and to the securing thereof by precautionary steps under procedural law.

The requirements to be satisfied for such an intervention must be legally regulated with sufficient clarity and specificity.

In the state of Hesse, section 7a, paragraph 1 of the HMRVG stipulates that:

Treatment regimens…are permissible…against the natural will of a detained person who is incapable of giving his consent if … significant danger for the life of the detainee or a serious impairment to his health exists" or if *"this is necessary to restore the detainee's ability to take decisions and action, as otherwise his discharge will not be possible*.

The law postulates that every human being has free will. Crucial for the existence of free will is cognitive capacity and the ability to act accordingly. When one of these elements is missing, there is no free will but natural will. Every human being, even mentally ill patients, are able to have a natural will. This is irrespective of whether this will is reasonable from the point of view of a third party. The natural will is a legal concept, which encompasses the actual intentions, desires, valuations, and intentions of a person, even if the latter is in a state of mental disturbance. Clarifying this with an obvious example: Ulysses wanted to hear the Sirens' song although he knew that doing so would render him incapable of rational thought. When Ulysses put wax in his men's ears so that they could not hear, had them tie him to the mast so that he could not jump into the sea, ordered them not to change course under any circumstances, and to keep their swords upon him and to attack him if he should break free of his bonds, he expressed his free will. When he upon hearing the Sirens' song, driven temporarily insane and struggling with all of his might to break free so that he might join the Sirens, which would have meant his death, he expressed his natural will.

In addition, compulsory treatment as defined in section 7a, subsection 2 of the HMRVG can be possible in the presence of significant danger to the life or serious impairment to the health of third parties.

When considering options for compulsory treatment, an advance directive must be taken into consideration (HMRVG section 7, subsection 2). The legislature is thereby extending the scope of an advance directive drawn up by the patient, even when the patient is in forensic psychiatric care. Other federal states have also explicitly included this in the texts of their laws [4,5].

The regulations governing the requirements for advance directives drawn up by patients as defined in section 1901a of the German Civil Code (Bürgerliches Gesetzbuch [BGB]) came into effect in 2009 [6]. With this amending law, Germany has formalized the use of advanced directives in legislation. The law is therefore colloquially referred to as the law on advanced directives ("Ulysses clause" in other countries).

In the advance directive, the patient may refuse future courses of treatment, limit them, or consent to them in advance [7]. The specifications must be in accord with the current life and treatment situation [6]. In the event of an acute psychotic episode, for example, the use of a certain antipsychotic drug may be ruled out or specified, or the use of all medication may be banned. Thus, the individual concerned is able to rule out compulsory treatment by means of their advance directive [8]. On the other hand, thanks to the statutory ruling in section 1901a of the German Civil Code (BGB), the individual concerned can actually express their wish for a certain course of treatment in certain circumstances.

Whether or not this goes as far as to request a course of treatment against one's own will in the context of the advanced directive is to be discussed in the following section, with reference to the practical experience of a forensic unit as well.

Practical aspects of advance directives: a case illustration

Up until now there have been two patients at the Vitos Hospital for Forensic Psychiatry in Haina who drew up advance directives prior to their admission to hospital in which they refused a pharmacological course of treatment (in one case the patient refused psychiatric examination and

the formulation of a psychiatric diagnosis as well). In such cases, it is necessary to determine as accurately as possible whether the patient actually considered placement in forensic detention when the advanced directive was drawn up ("in accord with the current life … situation"). This particular situation will have been anticipated in only the rarest of cases [9].

In terms of detention in a forensic unit, it must be noted that treatment may be carried out, if there is a danger to third parties (endangerment of third parties) [9-11], even when the patient's advance directive states that treatment is to be refused, and that state law provides the option of compulsory treatment [4,12].

By contrast, there are now 13 patients at the Vitos Hospital for Forensic Psychiatry in Haina who - in the course of their treatment there - have specified in their advance directives that in the event of an acute psychotic episode they wish to be treated with certain neuroleptic medications *even in the form of compulsory treatment*. The patients were well into or fully in remission, they had full insight into their illnesses and treatments after education on psychological and psychiatric illnesses and treatments, and they felt that their quality of life had clearly improved in remission. They realized and/or considered it possible that they would refuse, again, to be treated appropriately when in an acute psychotic state, and subsequently drafted advance directives to prevent this: they specified that if they should experience an acute psychotic state in the future, they should be treated even against their will (i.e. coerced into treatment). The patients viewed this as the best chance of going into swift remission again, and hence, minimizing the danger of lasting impairment (e.g. residual symptoms). When drafting their advance directives, upon request, the patients were given detailed legal advice and support by the hospital's in-house attorney, or they consulted with an external attorney, or their court-appointed authorized carer, for advice.. Prior to this, their ability to give informed consent was checked and attested to by a psychiatric specialist.

The following case history illustrates a prototypical situation:

Case illustration

Mr. T. was born in 1981. His parents separated when he was three years old; otherwise his childhood was unremarkable. Over the course of his youth and adolescence, he experienced problems with concentration. Moreover, Mr. T. was expelled from school in the 8th grade; his subsequent attendance at a vocational high school also ended with expulsion. All social relationships suddenly came to an abrupt end. In retrospect, it appears that Mr. T. was already in the prodromal phase of his illness at that time.

In 2004, the existence of a psychosis was suspected during an assessment. In 2005, the patient underwent compulsory treatment as an inpatient in a psychiatric ward for the first time after posing a danger to himself and damaging property. At that time Mr. T. was suffering from acoustic hallucinations and distressing delusions. However, no consistent further treatment with medication was provided. Further civil commitments to psychiatric units followed, during which the diagnosis of Schizophrenia was repeatedly confirmed. Mr. T. first came to the attention of the criminal justice system in 2007 when he committed theft and drove a vehicle without authorization. There followed a number of convictions for unlawful entry, damage to property, and threatening behavior/intimidation.

Finally, during an acute psychotic episode in 2010, Mr. T. committed the offenses of assault with actual bodily harm, as well as resistance to and insulting law enforcement officers, for which he was committed by court order to forensic psychiatric care under Section 126a of the German Code of Criminal Procedure (Strafprozessordnung [StPO]). According to Section 126a of the German Code of Criminal Procedure (Strafprozessordnung [StPO])), persons who are suspected of having committed a criminal offense may be admitted to a psychiatric hospital if there are urgent reasons to assume they were not criminally responsible or have acted in a state of diminished responsibil-

ity. A psychiatric assessment was carried out.

During his admission to hospital, he displayed dysphoric agitation, formal thought disorder and mildly delusional ideas with regard to the "military" and the "German armed forces". Due to his consistently negative and hostile attitude, proper structured conversations with him were hardly possible; he absolutely refused all treatment with medication and other forms of therapy.

Mr. T. appealed against the sentence of March 2011 for the placement in a forensic psychiatric hospital in accordance with section 63 of the German Criminal Code (Strafgesetzbuch [StGB]). The version of the Forensic Commitment Act of the State of Hesse in force at that time did not allow compulsory treatment.

The frequency and intensity of his impulsive outbreaks of aggression increased in mid-2011. After Mr. T. was informed that the German Federal Court of Justice [Bundesgerichtshof] had thrown out his appeal, he barricaded himself in his room. Due to this escalation, an intervention with medication was carried out as part of an emergency treatment (Section 34 of the German Criminal Code [StGB]), after which Mr. T. said he would be prepared to take medication on a voluntary basis.

The consistent intake of an antipsychotic drug resulted in a rapid regression of the acute symptoms, and his delusional thought disorders, impulsive behavior and mood swings attenuated significantly. In the further course of treatment, it increasingly became possible to discuss the offenses for which he had been placed in a forensic psychiatric unit and factors relevant to these offenses. Finally, in February 2012 it was possible to move the patient from the secure unit to a therapy ward so that he could be treated appropriately with regard to his criminal behavior and his medication optimized.

After a few weeks, it was possible to grant him extensive privileges. Under the increasing demands of the everyday routine, Mr. T. soon proved to be more thin-skinned and fatigued, so that his medication was switched from olanzapine to aripiprazole. After this, he was clearly more agile and more relaxed in his contact with others.

Mr. T. then joined a psychoeducation group, via which he acquired an understanding of his disorder and was able to relate the acquired knowledge to his own case history, so that he developed differentiated insight into his illness and treatment. He himself stated that he wanted to learn to handle the constraints resulting from his illness in the best possible way. He said that the treatment had rendered him more flexible in thinking, that he felt more relaxed, that he was not so distrustful, and that he found life worth living again. In February 2013, Mr. T. was transferred to an open rehabilitative ward and mastered this transition without any difficulty at all.

In May 2013, the patient stated that he wished to draft an advance directive. The focus of the directive was to be on pharmacological treatment, even against his possibly expressed natural will, if, owing to acute psychotic decompensation, he failed to see the necessity for treatment, so that he would be subjected to compulsory treatment. The patient explained that his involvement with the psychoeducation group for schizophrenic patients in conjunction with the switching of his medication from olanzapine to aripiprazole contributed to the development of this desire. He was able to recognize that he had schizophrenia and that after his medication had been changed, he felt very much mentally intact again and free from any side effects. He added that the combination of psychoeducation and successful treatment had nurtured the desire in him not only to be fully healthy, but also to remain that way.

Beginning in summer 2013, Mr. T. completed an internship as a municipal green area maintenance worker and street cleaner and was later hired on a permanent basis. In April 2015, Mr. T. was released on probation.

Looking back, Mr. T. said he found the detention and compulsory treatment extremely unpleasant and that he considered

it wrong at the time. He stated that today, however, he saw the compulsory treatment as a “crass method” that in his case had actually worked, so that he wanted to specify compulsory treatment in an advance directive as the method of choice for himself in the event that he experienced recurring episodes of illness.

Conclusion

In light of the fact that in the scenarios being discussed, these are patients who are aware that they are committed to court-ordered treatment in a forensic facility, and who are familiar with the phasic course of their disorder. With respect to the advance directive, the following factors should be considered:

1. In a phase when the patient is capable of expressing informed consent, the affected patient wishes to deliberately specify arrangements for treatment for the phases in which the patient is not capable of giving informed consent.
2. In the event of such a situation, the patient may be able to contribute actively towards shortening the acute treatment (possibly by several months), as drug treatment can be initiated immediately (subject to compulsion if necessary). In the German federal state of Hesse, treatment given against the will of the patient during court-ordered treatment in a forensic facility can be carried out without a corresponding advance directive only after a time-consuming application procedure (section 7a HMRVG).

It remains necessary to examine the legal question of whether a patient is able to stipulate in advance that if they are to become incapable of giving consent as a result of their disorder, compulsory measures can nevertheless be carried out contrary to expressed natural will. These questions are discussed in the literature from a variety of standpoints, yet there is still no conclusive solution that serves the interests of the persons concerned.

In conjunction with this, the following legal issues arise: can the patient consent in advance to a compulsory measure via a directive drawn up in anticipation thereof? Must the patient’s natural will, subsequently declared and in conflict with the advance directive (no treatment now!), be deemed a revocation of the previously drafted directive? This is tied to the question of whether the patient must be capable of giving his consent in order to declare his revocation.

None of these issues have been consistently decided in the legal literature or jurisprudence, nor have they been rigorously pursued to achieve solutions.

In particular, the aspect of the *ability to give consent in declaring a revocation of the patient’s directive* has been the focus of controversy [7,13]. Yet, the opinion [14] that would accept a revocation as valid merely by virtue of the articulation of a natural will is unconvincing. This only debases the function of such a patient directive [11]. In particular, in the cases discussed here, in which the patient is familiar with the progression of their disorder and seeks to regulate precisely this situation, to interpret another natural will expressed in a condition of incapability (of giving consent) would not be appropriate [as with 7,15,16]. This is particularly true if, when in a state of capability to give consent, the patient explicitly stipulates the wish to be treated, even if they subsequently declare or wish something else. In this respect, it is recommended that the patient additionally specify in their advance directive that declarations are to be deemed valid even when contradicted by their natural will [17]. For this reason, the natural will declared later on, when the patient is incapable of giving consent, *cannot be deemed* to be a revocation of the patient’s existing advance directive. This is the only way that adequate consideration of and compliance with the will expressed in the patient’s advance directive will be ensured.

This inevitably leads to the question as to whether consent can be given lawfully and in anticipation to *compulsory treatment*, for this is a course of treatment against the expressed and contradictory natural will of the patient. Here as well, there is no clear answer in the literature. Three legal positions are to be distinguished. The question

is answered in the affirmative by Götz [15] and Hoffmann [16], as well as Bohnert [18] although Götz and Hoffmann both express doubts as to whether this would be in keeping with the current life and treatment situation. Götz [15], however, sees a possible solution in which the author of the advance directive, in describing the situation of therapeutic application, makes it clear that they are aware of the outcome of their declaration and that their stipulations in the advance directive apply even if at a subsequent time their natural will conflicts with them. A compromise is suggested in the literature that although it is possible to consent to compulsory treatment in advance, it should not be possible to waive procedural safeguards [11,13].

For the cases discussed here in which the patient, in the awareness of their condition and with the understanding of the commitment to and placement in a forensic unit and in the knowledge of the completely individual course of their own illness, drafts an advance directive specifying that they should receive treatment even if their declared other will is against this, the only logical conclusion is that this valid directive cancels other prerequisites and procedural requirements for compulsory treatment in a forensic unit (in the state of Hesse: approval of the supervisory authority as specified in section 7a of the HMRVG) and in the legislation governing official court-appointed carers (subject to the decision of a judge). This all the more so since consent to compulsory treatment is not unethical per se [18,19]. Thus, the patient's right to exercise self-determination with foresight and planning could be preserved by means of a binding directive that will be invoked only in the future. This option should at least be recognized in the cases described here. It remains to be seen whether the wishes for treatment specified in a patient's advance directive will hold up under judicial review.

Conflict of Interest: none

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ORIGINAL ARTICLE

Forensic psychiatry in the largest secure ward in Portugal: characteristics of the population and psychopharmacological intervention

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Forensic psychiatry is defined as a specialty of psychiatry in which clinical and scientific knowledge is applied to the legal system, both with regard to civil and criminal law. Nowadays, the largest security ward is in Coimbra, at the University Hospital. It comprises 111 patients: 91 males and 20 females. The aim of the security measures, according to the penal code, is the protection of legal assets and psychosocial rehabilitation. In our sample, the most frequent diagnosis was Schizophrenia (37.8%); Moderate Intellectual Disability (23.4%) and Mild Intellectual Disability (14.4%) were the second and third most frequent diagnoses. The criminal acts accounting for the most prevalent security measures fell under domestic violence (19.8%) first, followed by attempted murder (16.2%), and theft (14.5%). The elaboration of a therapeutic and rehabilitation plan is essential, and its aim is to diminish the person's dangerousness. It is fundamental to think of the safety ward as a health production space and not as a place of mere disease management or "dangerous states", thus trying to solve the patient's problems.

Key words

Intellectual developmental disorder, forensic care, Schizophrenia, pharmacological treatment pathways

Introduction

Forensic psychiatry is defined as a specialty of psychiatry in which clinical and scientific knowledge is applied to the legal system, both with regard to civil and criminal law [1]. One of the most interesting issues in this relationship between law and psychiatry is the problem of criminal responsibility [1], where it must be determined whether or not an individual was aware of the consequences of his/her unlawful action before or at the time of the action (*mens rea*). Should a person's capacity to understand the consequences of his/her actions have been impaired or diminished due to a mental disorder, article 20 of the Portuguese Criminal Code would apply.

In this article, the term "not criminally responsible" (NCR) is used as follows: *Not criminally responsible due to a mental disorder: 1- A person is not criminally responsible if, due to a mental disorder, he/she is incapable at the time of committing the act of appreciating its unlawfulness or of conforming his/her conduct in accordance with that appreciation; 2- A person may be declared not criminally responsible if due to a serious mental disorder (unintentional in nature and whose effects he/she cannot control, without being thereby censurable) he/she had had, at the time of committing the act, the capacity to appreciate its unlawfulness or to conform his/her conduct in accordance with that appreciation sensibly diminished; 3- The agent's proved incapacity to be influenced by punishment may constitute a sign of the situation defined in the previous number; 4- Criminal responsibility is not excluded when the mental disorder has been caused by the agent himself/herself with the intention to commit the act* [2].

Once an individual is found not criminally responsible, it entails that the mental illness was at the origin of the offense. The symptoms of their mental disorder are considered to be the cause of their behaviour. Therefore, managing psychiatric symptoms would aid in mitigating risk. Additionally, the probability of reoffending is related to the severity of the mental disorder and the likelihood of psychiatric relapse, but involuntary admission is not

necessarily justified simply with being found to be NCR. Instead, security measures appear to be justified when there is a high probability that the individual would relapse in a way that he/she would commit a similar unlawful action and would be found NCR for that act as well [3].

Nowadays, the largest secure ward admitting NCR patients in Portugal is in Coimbra, at the University Hospital. In total, it has 111 patients, 91 males and 20 females. These patients were deemed not criminally responsible on the account of a mental disorder for the offense they committed. The decision to admit them was made due to the level of risk they pose for public safety; secure units are necessary due to their status as dangerous patients with a high likelihood of reoffending in the future [2].

Once the NCR status is given to the accused, the issue of likelihood of reoffending and therefore their level of dangerousness becomes paramount. In accordance to the Portuguese Penal Code, the aim of admitting dangerous NCR patients to a secure unit is to ensure public safety and their psychosocial rehabilitation, with the ultimate goal of safely reintroducing these patients into the community. Placed safety measure(s) must be proportionate to the seriousness of the index offense and to the degree of dangerousness of the patient (Article 40, paragraph 3 of the Penal Code [3]), and cannot, under the terms of the Portuguese Constitution, be perpetual or be of defined or indefinite duration. Likewise, the duration of the security measure(s) cannot exceed the duration of the sentence for the crime committed (Article 30 of the Constitution of the Portuguese Republic). The security measure(s) may only be applied if the severity of the crime is proportional to the danger of the agent. The duration of the jail time as defined by the Portuguese Criminal Code according to the committed offense will indicate how long the patient who committed a similar offense could be detained in the secure unit; however, the effective time spent will depend on how long the patient remains a risk for public safety. The duration of the security measure(s) is initially decided by the court at the time of the NCR finding but can end at any time if the court is satisfied that the level of dangerousness that justified admission into the secure unit is no longer met. [3,4]. For serious crimes, where the sentence is longer than 5 years in prison, the shortest possible duration of the security measure(s) is 3 years. After the measure(s) has/have been implemented, a reassessment of the individual must take place every two years. At any time, a judge can order a new assessment to evaluate the clinical and behavioural characteristics of the patient [5,6].

This study aims to characterize the profiles of the patients found not criminally responsible and admitted in a secure Portuguese hospital as their characteristics complied with security measures criteria as per the Portugal Criminal Code. The benefits and limitations of such medico-legal framework will be highlighted.

Materials and Methods

A retrospective chart review was performed in the Forensic Psychiatry Program in Coimbra, Portugal, between January and March 2018. All patients admitted during that period of time were deemed eligible. Prior to receiving consent from all patients to access their chart of the purpose of conducting this study, the protocol was approved by our local Ethical Review Board. Digital and paper medical records of the inpatients were analysed. Their sociodemographic status, the types of crime they committed, the duration of the security measures, and the pharmacological treatment they received were recorded. As this is a descriptive study, no statistical analysis was performed.

Results

Sociodemographical data

The final sample included 111 subjects with an average age of 45.81 years old, ranging from 21 to 81 years old. Among our sample, 91% were younger than 65 years old. The average age of female patients was 46.19 years old (range 24 to 71). The average age of male patients was 45.52 years old (range 21 to 81). With

respect to gender, there was a predominance of males (74.1%, n=83) compared to females (24.1% n=27).

Index offense and legal outcome

The index offense that was associated most with the NCR finding and led to the placement of the security measure(s) was domestic violence (19.8%), followed by *attempted murder* (16.2%) and theft (14.5%) (Table 1). Most of the patients committed only one crime at the time of the index offense; 28.8% of the patients had committed more than one crime for which they were found NCR (n=32). 74.1% of the female population (n=27) and 30.1% of the male population (n=25) had committed multiple offenses overall.

On average, the minimum sentence duration was 2.66 years. The average maximum duration was 8.95 years. For women, the maximum penalty time was 6.52 years on average (ranging from 1 to 16 years), while for men the average time was 9.78 years (ranging from 1 to 25 years).

Table 1: Summary of the crimes

Offense	Number of patients (%)
Domestic violence	22 (19.8%)
Attempted murder	18 (16.2%)
Theft	16 (14.5%)
Murder	11 (9.9%)
Criminal offense	10 (9%)
Forest fire	8 (7.2%)
Possession/use weapon	6 (5.4%)
Qualified damage	4 (3.6%)
Threat	4 (3.6%)
Aggravated threat	4 (3.6%)
Rape	4 (3.6%)
Sexual coercion	1 (0.9%)
Driving Without a Licence	1 (0.9%)
Resistance to justice	1 (0.9%)
Qualified kidnap	1 (0.9%)

Psychiatric conditions

The most frequent diagnoses were schizophrenia (37.8%), moderate intellectual disability (23.4%) and mild intellectual isability (14.4%). Altogether, schizophrenia and intellectual disabilities account for 77.4% of diagnoses (Table 2). For females, the main diagnosis was mild intellectual disability (29.6%) and for males, it was schizophrenia (45.8%).

Among our sample, 40% had a concurrent disorder. Whereas concurrent disorder was found in 14.8% of the female population (n=4), it was found in 48.2% of the male population (n=40).

Pharmacological data

Oral antipsychotic drugs - Oral neuroleptics were prescribed for 90.1% of patients; 51.4% (n=57) received first generation antipsychotics and 71.2% (n=79) second generation antipsychotics. It must be noted that 66.7% (n=74) received neuroleptics from one of the generations as opposed to 33.3% (n=37) from both generations. On average, the patients were medicated with 1.41 ± 0.9 different types of neuroleptics. The maximum number of antipsychotic medications prescribed per patient was 5.

Depot antipsychotic drugs - Depot antipsychotic formulations were used in 47.7% (n=53) of the sample. Haloperidol was the most commonly used, with 85% of patients using it (73.4% took this on a monthly basis, with the rest taking it every 3 weeks). The mean dose of haloperidol per month was 146 mg (ranging from 50 mg to 300 mg). Risperidone, a long-acting injection, was used in 9% of the patients (n=5) and prescribed every 14 days. Paliperidone, a long-acting injection, was used in 5.7% of the patients (n=3), with monthly injections.

Mood stabilizer drugs - Mood stabilizer drugs were prescribed in 36% of the cases (n=40). Among this group, 62.5% (n=25) were taking Valproic Acid with a mean dose of 1000 mg per day, 7.5% (n=3) Topiramate, 10% (n=4) Gabapentin, and 15% (n=6) Carbamazepine.

Benzodiazepines - Most patients (72.1%, n=80) were taking benzodiazepines. For 10 patients (9%), two different types of benzodiazepines were prescribed. Regarding the type of benzodiazepines prescribed, Lorazepam was the most frequently used (55.6%) and Diazepam the second most used (18.9%). Choices for

types of benzodiazepines with long half-lives are highlighted.

Other drugs **-** Only one patient had a psychostimulant treatment (0.9%), Methylphenidate. Three patients were on anti-dementia drugs (2.7%). Antidepressant therapy was used for 20 patients (18%).

Table 2: Main diagnoses based on DSM 5 criteria

Notes: 1 – bipolar type; 2 - current or most recent episode manic, with psychotic features; 3 - persecutory type; 4 – severe; 5 – other (or unknown), severe; 6 - Intellectual Developmental Disorder.

Main diagnosis by DSM – 5	**DSM-5 code**	**Total of patients**	**Male**	**Female**
Frontotemporal Disease	294.11	2 (1,8%)	2 (2,4%)	-
Schizoaffective Disorder[1]	295.70	4 (3,6%)	1 (1,2%)	3 (11,1%)
Schizophrenia	295.90	42 (38,2%)	38 (45,8%)	4 (14,8%)
Bipolar Disorder[2]	296.44	2 (1,8%)	1 (1,2%)	1 (3,7%)
Delusional Disorder[3]	297.1	10 (9,1%)	6 (7,2%)	4 (14,8%)
Antisocial Personality Disorder	301.7	3 (2,7%)	2 (2,4%)	1 (3,7%)
Alcohol Use Disorder[4]	303.90	3 (2,7%)	3 (3,6%)	-
Substance Use Disorder[5]	304.90	1 (0,9%)	-	1 (3,7%)
Intellectual Disability, Mild[6]	317	16 (14,5%)	8 (9,6%)	8 (29,6%)
Intellectual Disability, Moderate[6]	318.0	25 (22,7%)	20 (24,1%)	5 (18,5%)
Intellectual Disability, Severe[6]	318.1	2 (1,8%)	2 (2,4%)	-

Table 3: Summary of drugs used in the sample

Drugs	**Number of patients (%)**	**Male patients (%)**	**Female patients (%)**
Oral Antipsychotics			
First generation	57 (51.4)	48 (57.8)	9 (33.3)
Second generation	79 (71.2)	64 (77.1)	15 (65.2)
Depot Antipsychotics			
Haloperidol	45 (40.9)	38 (45.8)	7 (25.9)
Risperidone	5 (4.5)	4 (4.8)	1 (3.7)
Paliperidone	3 (2.7)	3 (3.6)	-
Mood stabilizers			
None	71 (64)		
Carbamazepine	6 (5.4)	4 (4.8)	2 (7.4)
Gabapentin	4 (3.6)	3 (3.6)	1 (3.7)
Lithium	2 (1.8)	1 (1.2)	1 (3.7)
Topiramate	3 (2.7)	1 (1.2)	2 (7.4)
Valproic acid	25 (22.5)	19 (22.9)	6 (22.2)
Benzodiazepines			
Alprazolam	1 (1.1)	1 (1.2)	-
Clonazepam	10 (11.1)	7 (8.4)	3 (11.1)
Diazepam	17 (18.9)	11 (13.3)	6 (22.2)
Flurazepam	1 (1.1)	1 (1.2)	-
Lorazepam	50 (55.6)	42 (50.6)	8 (29.6)
Oxazepam	11 (12.2)	9 (10.4)	2 (7.4)

Discussion

This descriptive study is a snapshot of the individuals admitted to the largest forensic program in Portugal and their pharmacological treatment.

From the obtained data, we can infer that most inpatients in the security ward are young men. The main offense committed was domestic violence. However, there are differences when looking at patient gender; in the female population, the most frequent offense is attempted murder whereas in the male population, after domestic violence, the most two frequent are kidnapping and murder. The co-occurrence of two psychiatric conditions is frequent in our population; the most popular one is the consumption of psychoactive substances, which is commonly found in offenders suffering from a mental health condition [7]. In our sample, we found a prevalence of 40.5%, with a higher frequency in men. Schizophrenia and intellectual disabilities are the most common diagnoses, and altogether they represent 77.4% of the population. The presence of intellectual disability is much more frequent in men. Interestingly however, there are as many women diagnosed with intellectual disabilities as with a psychotic disorder, but there are double the amount of men diagnosed with a psychotic disorder compared to those with intellectual disabilities. Taking into consideration the impact of the intellectual disability in relation to violent behaviour is relevant when considering treatment options and appropriate placement in the community. Additionally, considering the severity of the mental illness(es) is important in ensuring stability; indeed, someone can offend due to an acute psychotic episode/relapse, an unfortunate and unexpected event, and others can offend due to recurrent and hard-to-treat psychosis associated with antisocial and aggressive traits.

As for the psychopharmacology, most patients are under therapy with antipsychotics, either in oral forms or in long-term injectable releases. The fact that we work with a population with particular characteristics (serious behavioural changes, resistant psychosis situations) very often makes the use of various antipsychotics for clinical stabilization necessary. Less than half of the patients were medicated with long-acting antipsychotic medications, in spite of its well-known advantages in patients with low adherence to therapy. Poor adherence to treatment does not only impact the clinical prognosis due to frequent relapses, it also directly and indirectly increases health-related costs for the community [8]. Depot medication helps decrease the number of the re-hospitalizations, better helps long-term stabilization of psychiatric symptoms, and helps promote follow-up for individuals lacking insight into their mental illness [9]. Increasing the use of long-acting injectable drugs in the future may contribute to a better prognosis of patients with psychiatric diseases.

Different medical algorithms suggest that the first therapeutic option should be second-generation antipsychotics [10,11]. First-generation antipsychotics are generally associated with extrapyramidal side effects, with increased hyperprolactinemia and, in the long term, tardive dyskinesia compared to second-generation antipsychotics. Another aspect to take into account is its therapeutic efficacy. Although the results are not replicated in all studies, there are those who suggest that first-generation antipsychotics may be less effective than second-generation antipsychotics clozapine, amisulpride, olanzapine, and risperidone [12]. Besides patients that require a mood stabilizer due to the nature of their mental illness (bipolar disorder…), the choice of this therapeutic class helps some patients control their impulses. Another frequently prescribed psychopharmacological class was benzodiazepines. These allow for control of anxiety throughout the day as well as sleep regularization. The most commonly used benzodiazepines were those with long half-lives, allowing a greater stabilization of anxiogenic levels throughout the day. Future studies should look at the efficacy in risk management depending on the type of antipsychotic used, as most of the patients suffer from a psychotic disorder; research about concomitant use of another class of

psychiatric drug would also be meaningful to optimize pharmacological treatment and focus on psychotherapy intervention.

Involuntary treatment within our population needs to be addressed. Indeed, lacking insight into their mental illness is often the main barrier to initiate pharmacological intervention. The peculiarity of Portuguese legislation is that involuntary treatment can be initiated under an involuntary admission status without any other legal requirement. The law established in 1998 in the Portuguese Mental Health Law addressed both issues involuntary treatment and involuntary admission [13]. Article 12 of the Portuguese Mental Health Law states that *1. Anyone carrying an acute psychiatric anomaly that by its nature creates a situation of danger of significant value, to themselves or others, of personal nature or to property, and refusing to accept necessary medical treatment, can be admitted to the adequate establishment'; 2. Admission (to said establishment) is permitted when someone who carries an acute psychiatric anomaly lacks the required insight to evaluate the sense and scope that lack of treatment would have, as it relates to consent and how the absence of treatment would be evidenced in a deterioration of their condition* (translated by the authors) [13]. Thus, involuntary hospitalization is an adequate answer before two distinct situations: 1) the patient may be a danger to themselves or other people; and 2) the patient does not have enough insight to understand the meaning and scope of the consent, and the lack of treatment deeply deteriorates his/her mental health. Involuntary treatment is specified in the 3rd section of Article 11 of the same law and states that the committed patient has to undergo the medically indicated treatments, without prejudice to the provisions of Article 5 (2). This provision relates to psychosurgery [13]. This implies that the simple principle of being involuntarily admitted is sufficient to force treatment. In the forensic situation, the patients are in fact under an involuntary admission, ordered by the Court; these patients cannot refuse to be medically treated.

Conclusions

Therapeutic interventions in a secure program dealing with NCR patients are based on clinical-forensic and social parameters [5]. The aim of the security measures, in accordance with the Portuguese Penal Code, is to protect the public and the psychosocial rehabilitation of the patients.

This paper allows us to better understand the outset of the largest forensic psychiatry program in Portugal by looking at a sample of patients found not criminally responsible and admitted into a secure unit in Portugal complying with security measures, and it looks at sociodemographic aspects, crimes and duration of security measures, and therapeutic protocols. The characteristics of the patient population (sociodemographic aspects, index offenses, duration of the security measures and therapeutic protocols) help identify the patients' needs and how to allocate the resources.

Polypharmacy is an obvious aspect of the care provided to these patients. This can raise clinical and ethical questions on a patient basis in relation to their ability to consent to treatment and the accumulative side effects; however, this also speaks to the difficulty in treating some individuals whose mental disorder is associated with violent behaviour. Therefore, a follow-up study should look in detail at patients receiving polypharmacy, in order to identify its pros and cons and if this fulfils both the goals of managing public safety and promoting rehabilitation. It is necessary to think of the secure ward as a health production space, trying to solve the patients' problems, and not as a place of mere disease management or "dangerous states".

Conflict of Interest: none

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LETTER TO THE EDITOR

The implementation of cognitive behavioural therapy for psychosis (CBTp) in a forensic setting: lessons learned and future directions

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Dear Editor,

Schizophrenia is a debilitating psychotic illness that affects approximately 1% of the population. Within the Canadian forensic psychiatric system, patients are detained under a provincial Review Board after being found not criminally responsible (NCR) on account of a mental disorder. Here, the prevalence rate of schizophrenia is 53% [1]. Even with the use of psychotropic medication, it is estimated that approximately only 25% of patients fully recover from the illness [2]. The presence of active psychotic symptoms increases the risk of violent behaviour [3]. Thus, psychological interventions have been developed to be employed in conjunction with medication to assist in managing or even reducing symptomatology.

It is well established that schizophrenia is associated with deficits in metacognition. This refers to cognitive abilities that allow individuals to think about their own thinking. Patients with schizophrenia have a greater tendency to jump to conclusions [4-6], be more resistant to changing their beliefs when presented with disconfirmatory evidence [7-9], and have difficulty interpreting and understanding other people's mental states [10,11]. These deficits are thought to contribute to the development of positive symptomatology [12-15]. Thus, addressing the role these beliefs play in the development of hallucinations and delusions may lead to changes in the ways patients think about their symptoms and perhaps even lead to a reduction in the symptoms themselves.

Cognitive behavioural therapy for psychosis (CBTp) is a widely implemented psychological intervention for the treatment of schizophrenia-spectrum disorders. The primary goal of CBTp is to assist patients in objectively evaluating their delusional beliefs and hallucinatory experiences. This allows patients to think about their experiences more flexibly so that they may attribute them to symptoms of their illness, rather than maintaining the belief that these experiences are true depictions of reality [16]. Meta-analytic studies have found that CBTp is effective in reducing positive symptomatology, with small to medium effect sizes [17].

Implications for forensic settings

Numerous protocols have been established for delivering CBTp [16,18,19]. Given the prevalence of schizophrenia within forensic settings, it is important to establish the validity of these protocols within this context. Forensic settings introduce a host of challenges that make the implementation of CBTp more difficult. Schizophrenia is associated with neurocognitive deficits [20], but some research suggests that violent patients with schizophrenia present with greater neurocognitive impairments than do non-violent patients with schizophrenia. O'Reilly et al. compared violent and non-violent forensic inpatients with schizophrenia. Violent patients performed more poorly than did non-violent patients on various measures of neurocognition, with moderate to large effect sizes. These findings suggest that forensic patients with schizophrenia with a history of violence may have more severe neurocognitive deficits than do those without a history of violence [21]. This is particularly relevant when working with pa-

tients who have been found NCR, as the offenses are often violent in nature.

In addition to the above, comorbidity is quite common in this population, including co-occurring personality disorders and substance use disorders [1]. There is evidence to suggest that personality disorders are associated with deficits in metacognition [22,23], though there are conflicting findings [24,25]. Thus, patients with comorbid schizophrenia and a personality disorder may be particularly impaired in metacognition when compared to patients with schizophrenia alone.

Taken together, forensic patients may not only have greater difficulty understanding the material taught in CBTp but also experience more severe deficits in metacognition than do general psychiatric patients. It is possible that forensic patients may be less responsive to CBTp because of these factors, highlighting the need for further research in this area.

Adapting CBTp for forensic settings

As part of the Forensic Psychiatry Program at St. Joseph's Healthcare Hamilton, we implemented an 11-week, group CBTp protocol for inpatients and outpatients found NCR. In order to be referred to this group, patients must have a primary diagnosis of a psychotic disorder or have exhibited positive symptoms either in the past or currently. The protocol was based on the CBTp manual authored by Wright et al. but adapted for an 11-week, group format [26]. Topics covered included identification of values and what interferes with accomplishing valued goals, psychoeducation about psychosis and conceptualizing the development of mental illness, emotion regulation, managing negative symptoms (with a focus on behavioural activation), coping with distressing thoughts and delusional beliefs, and coping with hearing voices.

The following adaptations were made. The number of sessions dedicated to each topic was reduced. While it would have been undoubtedly beneficial to spend more time on individual topics, this needed to be balanced with the patients' tolerance for the duration of the group. The case conceptualization stage was significantly simplified by structuring these sessions according to the Metacognitive Training Program (MCT) to accommodate a group-level format [27]. Lastly, a greater amount of time was dedicated to teaching the CBT model than what was originally recommended in the manual.

Patients were generally open and receptive to the content and provided positive feedback about the group at its completion. The primary reason for drop-out was decompensation and low motivation to engage in treatment.

Lessons learned

After the implementation of the group, there are a number of recommendations that can be made. Firstly, it is recommended that the structure of the group be modified. The first half of the group focused on fundamental concepts (e.g., psychoeducation, emotion regulation, thinking styles) and did not specifically address managing psychotic symptoms. This led to confusion among patients as to the overarching purpose of the group. Further, to reduce the number of sessions, less time was spent on these fundamental topics than was needed. Patients had difficulty understanding the content, which affected their ability to understand the material taught in later sessions that built on these concepts.

Given the above limitations, it is recommended that CBTp be offered in two parts. Part one would consist of more general concepts taught in CBT, including psychoeducation about illness, emotion regulation, the roles of fear and avoidance, and problematic thinking styles. Part two would consist of concepts specific to CBTp, whereby patients use the knowledge and skills obtained in part one and apply them to managing their positive and negative symptoms, such as disputing delusional beliefs, coping with voices, and increasing behavioural activation. Additionally, addressing values and how symptoms interfere with valued goals would be better addressed in part two, when patients have a greater understanding of what their symptoms are.

Dividing the material in this way offers several advantages over the original format. First, the purposes of the groups will be clearer to the patients: Part one would focus on understanding and managing one's illness and improving cognitive flexibility, while part two would emphasize managing specific symptoms. This also allows for a greater amount of time to be allocated to each topic without overwhelming the patients, which may lead to a greater understanding of the content and more therapeutic gains. Additionally, this format may aid in retaining those who have low motivation for treatment, as the goals of the group would be clearer.

In addition to this structural change, there are several general changes that are recommended. The vocabulary and concepts taught in the group need to be simplified, as patients had difficulty understanding the material. It may be helpful to teach patients about problematic thinking styles in a more explicit format. Recent research into psychosocial interventions for schizophrenia has become increasingly focused on targeting cognitive biases, rather than symptoms directly. MCT, a standardized protocol designed to be delivered in individual and group formats, teaches patients to become more aware of and correct cognitive biases [27]. Findings generally support that MCT reduces cognitive biases, but there are mixed findings with respect to its effect on symptomatology [28-32]. Thus, it may be effective to have patients first complete MCT followed by CBTp, which may lead to a greater reduction in both cognitive biases and symptomatology.

There are several limitations that are important to highlight. Because this was not a clinical trial or formal program evaluation, patient characteristics were not collected for the purpose of analysis. As a result, it cannot be stated definitively that the patients who participated in this group exhibited the same clinical characteristics described in previous research with forensic psychiatric samples (e.g., comorbid diagnoses, neurocognitive deficits). As such, it is possible that the above recommendations are beneficial in both forensic and non-forensic settings. Indeed, any adaptations that improve patients' abilities to understand the material are likely to be effective regardless of the setting. Additionally, clinical outcomes were not measured, and there was no comparison group. As a result, statements regarding treatment efficacy cannot be made. Rather, the purpose of this paper was to conduct a qualitative evaluation of the CBTp program offered at SJHH.

In conclusion, it is feasible to implement CBTp in a forensic setting. Several adaptations need to be made to accommodate this population's level of functioning, motivation, and tolerance for psychosocial interventions, however. Future research should consider delivering CBTp using a phased process, whereby patients first learn fundamental concepts associated with CBT more generally, which can later be followed by strategies that address specific symptoms of psychosis.

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LETTER TO THE EDITOR

Scales for evaluating the acceptance of the rape myth: benefits and limitations

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Dear Editor,

Society's views regarding rape and sexual aggression have significantly evolved in recent years. Rape is now a felony, and the context of marital rape is an aggravating circumstance. Nonetheless, common representations could tend to minimize the perpetrator's responsibility and to excuse their actions. This shows acceptance of a set of attitudes, beliefs and stereotypes that we call the Rape Myth. Acceptance of these representations or of the Rape Myth is widespread, including among those who work in the legal and healthcare fields and among jurors, and may lead to a reduced penal response [1,2]. It also exists among rape victims and may prevent them from reporting the events or being able to reconstruct them precisely [3]. The existence of strong correlations between acceptance of the Myth and a propensity for rape and other coercive sexual behaviour [4-7] underscores the importance of this factor. In this way, the acceptance of the Rape Myth could lead to cognitive distortions that rationalize, minimize or justify the behaviours of sexual offenders [8,9]. Cognitive distortions also serve to protect sexual abusers' image so that they do not feel guilty, blame themselves or consider themselves to be monsters.

In order to study how widely the Rape Myth is accepted and how far-reaching its consequences are, it must first be measured. Today, a number of different scales are in use. Since the concept first appeared in the 1970s, the Myth's definition has evolved, leading to the creation of some thirty scales. We shall present the main ones in the following paragraphs.

The evolution of the scales

An initial scale created by Field in 1978 [10], the "Attitudes Toward Rape Scale" (ATR), includes 32 items yielding eight factors: *(i)* "*Women are responsible for preventing rape"*; *(ii)* "*Sex is a motivation for rape*"; *(iii)* "*Rape is punished harshly*"; *(iv)* "*Victims play a role in precipitating rape*"; *(v)* "*Rapists are normal*"; *(vi)* "*Power is a motivation for rape"*; *(vii)* "*Women's perception after rape is favorable*", and finally *(viii)* "*Women's normal attitude during rape is resistance*". This scale's constructs and psychometrics were of moderate quality. Costin created a scale derived from the ATR in 1985, the twenty-item "R-Scale" (for "Rape scale") based on three factors: *(i)* "*Women's responsibility in rape*"; *(ii)* "*The role of consent*" and *(iii)* "*The rapist's motivation*" [11]. Criticism of this second scale overlaps with criticism of the original scale – weak psychometric properties and highly cross-correlated factors that reflect a single overarching factor rather than a multidimensional structure [12]. The ATR and R-Scale were nonetheless pioneering tools for research on the Rape Myth.

Rape Myth Acceptance Scale

The first scale to use the Myth terminology was developed by Burt [13]. This was the "Rape Myth Acceptance Scale" (RMAS), made up of 19 items in 6 belief categories and based on research by the feminists of the time: *(i)* "*Nothing happened*"; *(ii)* "*No harm was done*"; *(iii)* "*She wanted it*" or "*She liked it*"; *(iv)* "*She asked for it"*; *(v)* "*Only mentally ill men commit rape"* and

(vi) "*Men cannot control their sexuality*" [13,14]. While it has been widely used ever since, its psychometric and conceptual qualities have been criticized repeatedly because of the wording of the items, their complexity and specificity, and the fact that the last ones, which are assessed as percentages, do not really correspond to beliefs or stereotypes [15]. According to several authors, the RMAS should be seen as a measure of the acceptance of violence against women rather than of the Rape Myth [16,17], as it is structured to take into account three factors: *(i)* "*Denial of rape accusations*"; *(ii)* "*Victim's responsibility*" and *(iii)* "*Rape claims seen as manipulation*" [18]. Nonetheless, the RMAS does serve to highlight associations with traditional gender role stereotypes, adversarial sexual beliefs and the acceptance of interpersonal violence, even though Burt also designed scales used to assess these concepts, which were criticized from a conceptual point of view [16,19]. Adversarial sexuality beliefs are defined as "(…) *the expectation that sexual relationships are fundamentally exploitative, that each party to them is manipulative, sly, cheating, opaque to the other's understanding, and not to be trusted*" [13].

Illinois Rape Myth Acceptance Scale

Payne et al. proposed another acceptance scale in 1999, the "Illinois Rape Myth Acceptance Scale" (IRMAS), in which they attempted to provide a precise, rigorous definition of the structure underlying the Myth, which may be understood both as a unit (a single, overarching factor), or as something multidimensional [19]. They argued that each dimension of the beliefs defining the Myth may have a different function in different people, which may explain in part why the degree of acceptance may vary for an individual. Thus, for women, the fact of telling themselves that rape only happens "to certain types of women" protects them against their own vulnerability and the subsequent anxiety or fear of falling victim to it themselves. The IRMAS is made up of 45 items structured around seven factors: *(i)* "*She asked for it*"; *(ii)* "*It wasn't really rape"*; *(iii)* "*He didn't mean to, that wasn't his intention*"; *(iv)* "*She wanted it"*; *(v)* "*She lied*"; *(vi)* "*Rape is a trivial event"* and *(vii)* "*Rape is a deviant event"* [19] . The independence of these factors has not been clearly demonstrated [12,21]. An abridged 20-item version of the IRMAS has been developed, the "Illinois Rape Myth Acceptance Scale-Short Form", which assesses the Myth in an comprehensive manner with good psychometric qualities [19].

Acceptance of Modern Myths about Sexual Aggression Scale

Gerger et al. are the authors of the "Acceptance of Modern Myths about Sexual Aggression Scale" (AMMSA) [12]. They developed this scale after observing low acceptance rates of the Rape Myth in studies based on the previous scales, a major disadvantage for its use in rape prevention, where the goal is precisely to reduce rates of acceptance. The authors hypothesized that this "ceiling effect" was not necessarily due to a decrease in prevalence, but rather to two elements: *(a)* an effect of "social desirability", since thanks to sexual aggression prevention campaigns, people are more aware of what is socially permissible; *(b)* the Rape Myth has evolved, and the original scale items are no longer suited to its measurement. To correct for this second aspect, the items were subtly reworded to cover all beliefs linked to the Myth concept. The AMMSA includes 30 items structured into five categories: *(i)* "*Denial of the scope of the problem*"; *(ii)* "*Antagonism towards victims' demands*"; *(iii)* "*Lack of support for policies designed to alleviate the effects of sexual violence*"; *(iv)* "*Beliefs that male coercion forms a natural part of sexual relationships"*, and *(v)* "*Beliefs that exonerate male perpetrators by blaming the victim or the circumstances*" [12]. But only one factor accounts for the concept in a holistic way (with Cronbach alpha coefficients of 0.90-0.95, depending on the study). Its psychometric qualities have been demonstrated in its English, German, Greek, and Spanish versions [20,21]. An abridged 11-item version was developed in German and French [22], but its authors have not supplied all the elements required for an assessment of its psychometric qualities and its relevance.

In line with Gerger et al., who claim that the Rape Myth is highly dependent on the cultural context and that scales of measurement should be adjusted for changes in language and subtler myths [12], McMahon and Farmer developed their own 22-item scale [23] derived from the "Illinois Rape Myth Acceptance Scale" (IRMAS) of Payne et al. [19] by modifying those items judged too explicit and rewording all items with more contemporary vocabulary (including using a number of slang expressions). They retained only four of IRMAS' seven subscales: "*She asked for it*"; "*He didn't mean to"*; "*It wasn't really rape"* and "*She lied"*. Its generalizability is limited due to the wording of the items and the fact that it is targeted at students.

We have not mentioned all the scales measuring the Myth of rape (about thirty in total), but only those that are the most widely used or that have inspired others. An example of the scales not included is the Perceived Causes of Rape (PCR) created by Cowan and Quinton [24], which has 30 items covering five factors: *(i)* "Male dominance"; *(ii)* "Society and socialization"; *(iii)* "Female precipitation"; *(iv)* "Male sexuality, and *(v)* "Male hostility. However, it was not developed only to investigate the rape myth and it also includes sociocultural representations (Male dominance and Society/socialization).

Conclusion

Acceptance of the Rape Myth has obvious consequences (from a social, individual, and clinical point of view). Despite the recent "Weinstein case" that has encouraged many victims of sexual assault to speak out, we seem to see certain forms of "resistance" to social change towards greater equality between men and women and to the denunciation of factors that contribute to violence against women. It is crucial to be able to act on the cognitions or representations that underlie acceptance of the Rape Myth, such as the idea that victims are responsible for what happened to them. This would help improve treatment not only for victims, but also for the perpetrators of sexual violence. The top priority is clearly to help teenagers and young adults recognize their gendered sexual beliefs and give thought to becoming a man or a woman, emotional and sexual relationships and the notions of respect and genuine consent between partners. In this regard, it should be noted that the existence of several scales related to Rape Myth reflects the interest of researchers in the concept and its structure, even if a lack of consensus on its definition may weaken findings in the area. While the use of such tools should take into account the investigated cultural context, the "Acceptance of Modern Myths about Sexual Aggression Scale" (AMMSA) developed by Gerger et al. [12] seems of interest both for its relevance (in particular since it takes into account social desirability) and for its psychometric qualities.

Conflict of interest: none

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